DEAN'S Notes™

Vol. 29, No. 4
March 2008

A Communications Service to Nursing School Deans, Administrators, and Faculty

Published by Anthony J. Jannetti, Inc. as a service to the National Student Nurses' Association, Inc.
EDITOR: JUDITH A. TYLER, MA, RN

The Science of Documentation

Amy Brown

Diana King

Documentation has always been an essential part of client care. Florence Nightingale first noticed the need for "gathering patient information in a clear, concise, organized manner" (Davis & Francis, 2006, p.366). Over the years, documentation has taken on many forms and has had many uses. The importance of concise and appropriate documentation is a must in order to provide quality health care.

The health care system continues to evolve with new processes to improve client safety and quality of care. The rules of documentation are as dynamic as the health care system itself. Abbreviations are constantly being manipulated, and the "do's and don'ts" are continually being prioritized. However, one thing has not changed—the chart is a legal document. Its purpose is to provide a summary of all observations and interventions taken to alleviate identified problems as well as client responses to the interventions, and most importantly, act as a communication tool between all members of the health care team.

The Chart as Evidence

Record keeping also has a vital legal purpose. It provides evidence of your involvement with patients and should be detailed enough to demonstrate that you have fulfilled your professional and legal duty of care. Delivering appropriate care can become litigious when actions are undocumented, are casually or inaccurately described, are completely unintelligible, or rely heavily on the use of in-house acronyms or abbreviations instead of an individual nurse's own words. For the nurse, it is self implicating to appropriately perform a task, then because of a complex work situation, fail to precisely describe those actions according to the requirements of the employing agency. Summarized, non-individualized documentation may occur because of work overload, lack of assistive staff, patient complexity, or nurse exhaustion.

Consequently, brief, often meaningless notes used to describe the care provided may be interpreted as a self-written admission of inappropriate treatment. Incomplete, inaccurate, or non-existent documentation, regardless of cause, may ultimately be considered negligence. With an estimated $500 million in compensation being paid from medication-related errors, the chart provides a reminder of the importance of the medical record as evidence. In respect to malpractice litigation, median and mean payments for all types of registered nurses were $100,000.00 to $302,737.00 in 2004. From 1990 through 2005, 19,918 nurses and advanced practice nurses filed Medical Malpractice Payment Reports with the National Practitioners Database (Irving, 2006).

Pictured L-R: Lt. Govenor of Kentucky Dr. Dan Mongardio; Amy Brown, MSN, RN, Assistant Professor of Nursing, MSU; Dr. Taufik Kassis, Community Family Clinic; and Diana King, MSN, RN, Assistant Professor of Nursing, MSU.

Charting cannot be viewed as a mechanical process by students, who need to understand that what they document matters. If it is not charted in the medical record, it can be hard to prove. Reinforcement that the chart must be approached as possible evidence is essential. An evidence-based care plan with appropriate interventions, evaluation, and progress notes support this approach. There is temptation to use jargon and unapproved abbreviations as a form of professional shorthand, especially in today's busy health care setting. This can dramatically increase the risk of miscommunication between health care professionals. Unfortunately, often the first impression the court has of you is from your nursing notes. If your charting is unprofessional, then the assumption will be made that you are as well, leading to the further assumption that the care you are providing to the client also may be questionable. This, in turn, can greatly damage your credibility as a witness.

Proper Documentation – A Complex Skill

How do you learn to document correctly? More importantly, how can we provide nursing students the best opportunity to practice this skill safely? Documentation is a skill that is accurately mastered by few. Nursing documentation is a complex process. A study identified related factors to poor documentation practice: limited nurses' competence, decreased motivation and confidence, ineffective nursing procedures, and inadequate nursing audit, supervision, and staff development (Davis & Francis, 2006). As proactive nursing faculty, we can eliminate many of these factors with education. We must also provide a positive mind frame when teaching the nursing process and its active role in nursing care. The same study interviewed nurses and found that most judged developing nursing diagnoses and care plans as an unnecessary burden.

They did not value the importance of nursing interventions and autonomy in everyday practice (Davis & Francis, 2006). This type of nursing attitude leads to viewing documentation as an unimportant task, and quality documentation is not achieved.

An estimated 15% to 20% of nursing work is spent documenting client care and information (Irving, 2006). Research has repeatedly found that it is inadequate in meeting criteria recommended in the literature, such as improving continuity of care and enabling evaluations to be carried out. (Davis & Francis 2006). How can we reinforce correct documentation techniques? It is our job to help students understand that documentation helps nurses identify themselves as knowledgeable and efficient, which in turn promotes the visibility of efficient assessments and thus, their legitimacy.

Impact of Technology and Nursing Informatics

The implementation of information technology into the health care setting is providing health care workers with a new type of documentation style. Nursing informatics is now moving toward a paperless system that will improve continuity of care for all clients. This rapid change in technology must, by necessity, become a means to accurately monitor and document patient care. Ultimately, electronic patient records will become the databases used to improve the efficiency, appropriateness, and rationale for care provided. Many barriers to quality care will decrease, such as duplication of handwritten data, medical errors due to illegible handwriting, misplaced pieces of client's charts, and the length of time to find and transfer medical records to other facilities. An electronic information system is more than just an alternative method of documenting client information. A well-designed system can capture important data that can be used to support administrative and financial decisions.

In an effort to support the development of information technology into the health care setting, President George W. Bush earmarked funds to establish electronic medical records (EMRs) in certain institutions for pilot studies. The President has expressed his commitment to ensuring that most Americans will have electronic health records by the year 2014 (Alberta, 2007). With that in mind, faculty must seek out opportunities for student exposure to EMRs in the clinical setting.

Guidelines for Documentation

Regardless of its style, documentation must follow standards of care and institutional policy and procedures. There are certain guidelines that can be taught to help ease the anxiety of charting for students. These include:

- Write legibly and with detailed conciseness.
- Base your documentation on your objective assessment findings using your senses of sight, touch, hearing, and smell.
- Document as close to the intervention time as possible.
- Always document evaluations of interventions or client status change.
- Never document an intervention that was done by someone else, such as medication administration.
- Avoid using terms that can be misinterpreted as bias or labeling.
- Leaving gaps or spaces is not advisable, nor is charting ahead of time (Alberta, 2007).

Electronic Documentation in Rural Communities

The Department of Nursing at Morehead State University (MSU) has struggled with a way to provide adequate guidelines to students consistently because many different health care institutions with varying charting methods are visited by our nursing staff. We are dedicated to finding a way to propel our students forward with advancing technology, such as with EMRs. We are looking for new opportunities to move student success forward with positive results. Providing clinical experiences in primarily rural eastern Kentucky also presents roadblocks in areas of education on documentation skill.

In rural communities, continuity of care is often difficult to provide. There are many barriers to health care, including the regular inability to obtain patient medical records to treat those who present with some of the many diseases plaguing the nation. Lack of funding to initiate and support transitioning to a complete paperless system also exists. Eastern Kentucky is no exception. In fact, health factors rate the county of Menifee, as one of the poorest in the state of Kentucky. Menifee County statistics exceed the state statistics in the areas of smoking (both adult and youth), physical activity, obesity, primary care, cancer, and cardiovascular deaths (Kentucky Institute of Medicine, 2005). In a recent survey conducted by the Kentucky Center for Rural Health (2003), citizens listed cost and local access to adequate services as a reason they did not visit a primary doctor.

Menifee County is located in the MSU service region, and as advanced practice nurses, my colleague and I saw a need for intervention. Our focus was simple: how can we make caring for these clients more efficient, and therefore, improve quality and continuity of care? In addition, how can we provide a learning experience for our students? We partnered with a local physician in the community who also had a great concern for his clients and his ability to care for them in the most efficient manner. Dr. Taufik Kassis with the Community Family Clinic acknowledged a need for easier documentation, chart retrieval and electronic prescription ability for his office. He further described that this would increase time to spend with clients and allow better access in the acute care setting, if needed. This led to further discussion on the difficulty of providing a good environment in the clinical setting for effective documentation practice for nursing and other health care students on a regular basis.

Funding opportunities were researched with the local state government. A plan was developed to write a grant to fund the implementation of EMRs for the physician office, enabling community partnerships, and to provide interactive charting software for MSU's Department of Nursing students.

Developing community partnerships and bringing them on board were essential to the success of our grant. We worked with the local pharmacy to arrange the availability to send e-prescriptions for easier processing. Dr. Kassis wanted his clients to see the benefits from this advance in technology, and for this to happen, the outcomes must be client-centered. E-prescriptions allowed for decreased wait time at the only pharmacy. EMRs also allowed for quick replication and sending of charts, and the ability to retrieve charts in the acute care setting to decrease hospital admission times and length of stay. This, in turn, decreased the financial burden for all parties involved.

In October 2007, the grant was submitted to the local state government. We received one grant out of only four grants given for $25,000, which was used to implement an EMR system in a rural clinic, purchase interactive software for

the Patient Care Lab at MSU, and provide a learning experience for nursing students and faculty.

Conclusion

Our focus with students was clear. We wanted an interactive experience for the students with real results for constructive feedback. We also wanted all the facts about documentation reinforced. We needed the experience to be fun as well as promote critical thinking skills. The tool of choice also needed to have the ability to be integrated with either low or high-fidelity clinical simulation in order to move forward with advancing technology in the realm of academia. We also wanted to have student input on the project and have trial runs of certain software in the multi-media lab. We are currently running these small trials in our Nursing Fundamentals course, where documentation is first introduced. After all trials are completed with different software, data will be compiled and presented to the faculty. So far, this process has been extremely educational for all faculty involved. By involving the students with this process, we have been able to introduce how evidence-based practice can be used in all types of health-related areas of concern. Students are becoming empowered in their own education and are beginning to understand certain aspects of trial and error in relation to nursing research application.

The selection of our interactive nursing documentation software will be complete at the close of the spring 2008 semester. We will select the software that most sufficiently meets the needs of our students and promotes correct documentation and critical thinking skills. The implementation stage of the project will begin with the fall 2008 Fundamentals of Nursing class. The goal is to integrate electronic documentation at all levels as the initial class progresses through the program. We believe that opportunities for improvement are endless. It is our job as nursing faculty to constantly challenge our students to excel as well as promote positive outcomes for the communities in which we serve. Documentation may always be an upward struggle for some nurses and nursing students, but as nursing faculty, we must make every effort to provide experiences that will improve documentation skills, thus improving continuity of care.

Amy Brown, MSN, RN, is an Assistant Professor of Nursing, Morehead State Univeristy, Morehead, KY.

Diana King, MSN, RN, is an Assistant Professor of Nursing, Morehead State Univeristy, Morehead, KY.

References

Alberta, K. (2007). Documentation for registered nurses. *RN, 63,* 12-13.

Davis, C., & Francis, K. (2006). The study of nursing documentation complexities. *International Journal of Nursing Practice, 12,* 366-374.

Irving, K. (2006). Discursive practices in the documentation of patient assessments. *Journal of Advanced Nursing, 53,* 151-159.

Kentucky Institute of Medicine. (2005). *Statistical analysis, 2,* 22-26.

Kentucky Center for Rural Health. (2003). *Survey results, 1,* 8-10.

Once you have finished with this newsletter, please pass it along to share with a colleague or friend.

2008 Spirit of Nursing Award

The winner of the Army-sponsored 2008 Spirit of Nursing Award is Courtney Kohler, a senior nursing student from North Central Texas College, Gainesville, TX. Ms. Kohler will receive an all-expenses paid trip to the National Student Nurses' Association 2008 Annual Convention in Grapevine, TX, a beautiful statue award, and the printing of her essay in the *NSNA Convention News*.

Courtney's academic achievements are significant in importance and scope. She is a member of Phi Theta Kappa, a winner of the Collegiate All-American Scholar award through the U.S. Achievement Academy, and a recipient of the North Central Texas College Student Leader Award. She is also on the Dean's Honor List, has achieved Presidential Status in the National Honor Society of Leadership and Success, and has received the Lucille Kisling Scholarship. Her cumulative grade point average is an impressive 3.84.

Courtney is an active member of the National Student Nurses' Association and the Texas Nursing Students Association. She is the president of her school chapter and a Senator in the Student Government Association at her school.

Courtney is a very active college student and is involved in numerous community and school volunteer activities, including books for Africa drive, Toys for Tots, Susan G. Komen Foundation, teaching CPR to junior and senior high school students, and much more.

Ms. Kohler was selected from over 100 school winners by a committee from the U.S Army Nurse Corps and the National Student Nurses' Association.

Hartford Geriatric Nursing Initiative

Older adults make up the majority of our hospital patients today. Their numbers are growing, and meeting their health care needs is of vital importance to nurses caring for them.

Launched in 1995, the Hartford Geriatric Nursing Initiative (HGNI) is confronting the issues associated with an aging patient population through an array of programs. With a $60 million investment from The John A. Hartford Foundation, the HGNI is preparing professional nurses to play leadership roles in improving the health of older adults.

In partnership with the nation's nursing schools and a variety of health care organizations and systems, this dynamic, national initiative works in five areas, including:

- Shaping nursing practice to best meet the health care needs of older adults.
- Enhancing professional education to ensure all nurses are prepared to treat older patients.
- Promoting research needed to guide the care and promote the health of older people.
- Developing leadership in academic and professional settings.
- Demonstrating nursing's commitment to enacting public policy that improves older American' health care.

The Hartford Geriatric Nursing Initiative is a dynamic collaboration of the Hartford Institute for Geriatric Nursing at New York University; The American Academy of Nursing; and The American Association of Colleges of Nursing.

To learn more about this initiative, visit www.hgni.org or www.ConsultGeriRN.org.

DEAN'S Notes™

Editor . . . . . Judith A. Tyler, MA, RN
President, NSNA . . . . . Jennifer Davis
Executive Director . . . . . Diane Mancino, EdD, RN, CAE
Art Director . . . . . Jack Bryant
Managing Editor . . . . . Carol Ford
Graphic Artist . . . . . Melody Edwards
Publisher . . . . . Anthony J. Jannetti
Advisory Board . . . . . Barbara Chamberlain, DNSc, APRN
Susan Stone, MSN, RN

DEAN'S Notes is indexed in Cumulative Index to Nursing & Allied Health Literature.

DEAN'S Notes is published five times a year (September, November, January, March and May) by Anthony J. Jannetti Inc., East Holly Avenue Box 56, Pitman, New Jersey 08071-0056. Telephone 856.256.2300. FAX 856.589.7463.

PRSRT STD
US POSTAGE
PAID
Bellmawr, NJ
Permit #58

Marilyn Bagwell Leadership Development Fund

Creating change in any society takes an active participation from its members for changes to occur. Dr. Marilyn Bagwell, Professor Emeritus, Arizona State University, Tempe, AZ, strongly believes that the nursing profession needs well-prepared leaders to take on the challenges that face the profession of nursing and health care.

"Meeting our growing nursing demands requires that future nurses get involved during their college years," she said. "The state chapters and the National Student Nurses' Association (NSNA) facilitate the process of developing future professionals and advocating for high quality health care and advances in nursing education."

In 2003, the Foundation was pleased to announce the Marilyn Bagwell Leadership Development Grant Program, established by Dr. Bagwell, to get people involved in shaping the future of nursing. In addition, the grant was created to assist in nurturing future leaders in the nursing profession and in health care as a whole.

With the endowment growing through donations from more than a dozen nursing schools, the fund has begun providing grants (up to $1,000) to schools of nursing to support student involvement in the state chapters and NSNA. Grants can help schools establish an NSNA chapter or support travel expenses for students to attend state or national conventions.

In 2004, Harford Community College (HCC) in Bel Air, MD, was the recipient of the first Marilyn Bagwell Leadership Grant. That fall, HCC began a collaborative Mentoring and Membership Pilot Project with other schools of nursing in the state of Maryland to establish and promote involvement in their Student Nurses' Association and NSNA.

The 2005 winner was the Hopkinsville (KY) Community College Association of Nursing Students, and the 2006 award went to the University of Massachusetts at Amherst. Dr. Bagwell invites every nursing program to consider collecting contributions from nursing faculty to total $200 or more (per school). In this way, each school will help to grow the fund. Individuals and organizations may also contribution to the fund, with all FNSNA contributions tax deductible.

Special thanks are given to those schools that have already contributed!

For further information on the Marilyn Bagwell Leadership Grant or to make a contribution, please contact Dr. Diane Mancino, FNSNA Executive Director, at (718) 210-0705 Ext. 103 or via e-mail to diane@nsna.org